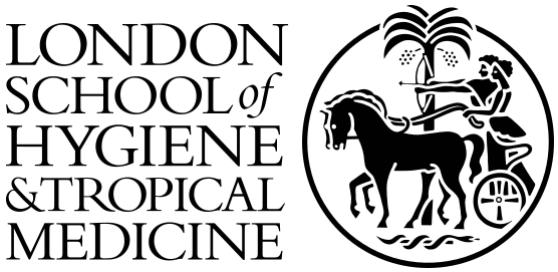

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Commentary

Reflections from South Africa on the Value and Application of a Political Economy Lens for Health Financing Reform

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INTRODUCTION

In the mid-1990s Michael Reich and Gill Walt, drawing on independent lines of work, called for an injection of political economy thinking into health policy analysis in low- and middle-income countries (LMICs). Reich noted that "policy reform is inevitably political because it seeks to change who gets valued goods in society"[1(p49-50)] and Walt, that health policy is "concerned with who influences whom in the making of policy, and how that happens.[2(p1)] Both concluded that neither primarily technical work, such as economic analysis, nor a well-designed policy are themselves enough to bring about policy change. Rather, deliberate and specific analysis of the wider political forces, the actors, processes and power, influencing such change is necessary to understand its political feasibility—and to consider how to support the process of change.

As we approach 2020, the call for Universal Health Coverage (UHC) has ensured that health financing reform is on policy agendas around the world. Such large-scale health financing and system reform is quintessentially political—given that interests compete, there is much to gain and lose, and the current institutional status quo is inevitably challenged. It is no surprise that health financing reform is being contested and debated in parliaments as well as publicly from the highest to lowest income countries.

Yet, there remains barely any political economy analysis of health financing reform in LMICs. Although there is no current mapping of literature in the field, only 13 out of 100 exemplar papers included in the 2018 LMIC Health Policy Analysis Reader had an explicit focus on financing policy.[3] Earlier mapping reviews have demonstrated the small and fragmented nature of the overall field, and its limited consideration of health financing issues. In an overall field review for 1994–2007, only 15 out of 164 empirical papers addressed such issues[4] and over

a slightly longer period (1994–2009), only 6 out of 86 empirical papers specifically addressed financing policy implementation (that is, the experience of putting policy into practice within the health system).[5]

This special issue of *Health Systems & Reform* on the Political Economy of Health Financing Reform is important, then, in bringing attention to the importance of applying a political economy lens both in understanding the challenges of health financing reform in the UHC era and, critically, in thinking through strategies to support its implementation. The articles in this issue present a political economy framework for analyzing policy experience,[6] as well as various examples of its application.

In this commentary, the framework is briefly applied to understand the 25-year history of debate and contestation around large scale health financing reform in South Africa. At the time of the first democratic elections in 1994, it was widely recognized that significant restructuring of the fragmented, inequitable and inefficient health system inherited from the apartheid era was needed.[7] Twenty-five years later it has, however, not yet been possible to secure sufficient political and popular support for any set of related proposals.

This commentary first uses the framework[6] to explore what forms of contestation around financing reform in South Africa explain the failure to achieve policy change. Second, it presents four general reflections about the use of the framework by government strategy teams tasked with supporting health financing reform.

SOUTH AFRICAN HEALTH FINANCING REFORM EXPERIENCE 1994–2019

The run up to the May 2019 South African general elections saw vigorous public debate focused on the needs for and constraints to implementing the 2018 National Health Insurance (NHI) Bill, given what newspapers have generically called: "the collapse of the public health system"; revelations of broader state and public sector corruption (widely known in South Africa as "state capture"); concerns about supplier induced demand and other pressures underlying rising costs in the private health sector, and the government's difficulties in adequately regulating this sector (see various reports at https://www.dailymaverick.co.za/author/spotlight/). By establishing a central funding organization that would pool public and private financing and act as the primary purchaser within the health system, this Bill essentially seeks to support equity in financing by enabling cross-subsidization within the health system, as well as leveraging efficiency gains. A future public/private provider network is also envisaged, with primary health care providers managed by a strengthened District Health System (DHS) and primary health care contracting units within the public sector.

This is just the latest turn in the 25-year process of recurring policy debate about comprehensive health financing reform since the first democratic elections of 1994. In the late 1990s, a first set of commissions and committees considered what was then termed "Social Health Insurance," as well as reform of the private insurance (medical aid) industry. They delivered insurance reform (the 1998 Medical Schemes Act) but not wider reform.[8,9] Although agenda setting continued in the 2000s,[10] there was little significant policy development after 1997—in large part because national health policy priority attention was then focused on how to respond to the HIV/AIDS epidemic.[11] It was only after the 2007 leadership change within the ruling African National Congress (ANC) party that NHI was brought squarely into the policy debate.[10,11] The 2011 publication of the NHI Green Paper demonstrated renewed political commitment to significant health financing and system reform, and this was (after delays) reaffirmed by the 2015 NHI White Paper, and the 2018 NHI Bill. Following the May 2019 national elections, the country waited to see what would happen next; and in early July 2019, the new Minister of Health announced that Cabinet had approved the Bill for tabling in Parliament for public consultation.

Underlying this long history of recurring policy debate lies contestation among powerful groups, competing policy interests and pressures within and across sectors, and an evolving context. The political economy framework[6] helps understand these forces.

As summarized in Table 1, leadership and budget politics have consistently shaped the process over time—reflecting imperatives and tensions within the wider political and economic context, and economic policy imperatives. Political contestation within and beyond the ANC and fragmented authority to drive NHI policy forward, with particular disagreements between national Treasury (Finance) and Health officials, have been recurring blocks to policy progress.

Amongst interest groups, the broadly government-aligned Trade Union federation has become a supporter of NHI over time, and perhaps with growing influence[11]; whilst the position of health professionals and some private health sector actors has often been unclear, or perhaps just not well understood. Waterhouse et al.[11] highlight examples of how private health sector actors have used their financial and technical capacity to influence other health policy areas and report speculation that politicians and senior civil servants are influenced by private health care interests. Table 1 suggests, however, that none of beneficiary, bureaucratic or external

	1994–1999[7]	2000–2010[9]	2007–2017[10]
Summary, financing policy process	Free care implemented for mothers and children, and for PHC generally. No policy agreement around broader financing reform, despite several waves of technical discussions in open and closed committees	Policy discussions continued behind closed doors in technical commissions until 2008/9, when the President and national Minister of Health made public statements to NHI	Pace of NHI development inconsistent, with continuing technical work conducted behind closed doors. Green Paper released in 2011, but White Paper not released until 2015. Work streams established 2016 to develop further details of the proposals. District NHI pilot sites established in 2012.
Interest groups politics	Largest Trade Union federation aligned with government, though did voice opposition to 1997 SHI policy proposals Insurance industry divided and in weak position post-elections, so weak influence on policy process	Support for moves towards NHI from wide range of health and non-health Trade Unions Private sector (insurance industry & providers) position unclear, not publicly stated but seem to have engaged in policy process Health professionals as part of middle class may have had influence in pushing for NHI	Largest Trade Union federation highly supportive of NHI and publicly criticized Health and Treasury leadership for obstructing NHI Private sector assumed to oppose NHI, but support has been expressed by insurance and provider actors given opportunities to have roles in the future system*(some provider groups vocally opposed to reform)* General Practitioners 'disgruntled' but little engagement with them or with professional associations; Medical Association resisting NHI
Bureaucratic politics	Not raised as influence *(new provincial governments not sufficiently well established to take positions on financing reform)*	Not raised as an influence *(primary health focus of provincial governments was addressing HIV/AIDS crisis)*	Competition Commission's Health Market Inquiry (on private sector) may impact on NHI Other regulatory bodies too weak to fulfill mandates Provincial departments resist centralization of power proposed under NHI *(Government employees fear loss of own, current insurance benefits)*
Budget politics	National Treasury (Finance) officials opposed all SHI proposals presented on grounds of likely impact on tax levels; controlled public sector resource allocations within national government and across provinces	Position of Treasury (Finance) not specifically considered *(but broader economic concerns likely to have maintained caution or opposition to S/NHI)*	National Treasury (Finance) officials remain cautious, given e.g. broader economic considerations, concerns about national Health department capacity, & design details Wider political disputes between the President and Minister of Finance likely to have overshadowed NHI decision-making
Leadership politics	National Minister of Health strong political leader of health reform, with Presidential backing—but opposed 1997 SHI policy proposals	Political leadership focused on HIV/AIDS policy for most of the period Replacement of President Mbeki by President Zuma, as leader of ANC 2007, then State President 2009, and linked change of Minister of Health, led to political support for NHI as part of a populist platform	Broad Presidential support for NHI since 2009 Minister of Health is public champion of NHI—but personalized leadership style & little focus on implementation details are weaknesses National and provincial legislatures have limited influence Political tensions leading to replacement of President Zuma by President Ramaphosa as leader of ANC and State President in 2017, create pressure and uncertainty for NHI

(*Continued on next page*)

	1994–1999[7]	2000–2010[9]	2007–2017[10]
Beneficiary politics	Beneficiaries not engaged, considered around SHI	Despite public support for NHI, confidence in the public health system fell over time Towards end of period, Civil Society Organizations made public statements of support for NHI Growing middle class support for NHI, given increase in private sector costs	Civil Society has had little impact on NHI debates, although broadly supportive Little active public understanding and engagement, though potential for support
External politics	Not raised as influence *(country not dependent on donor funding and had global political backing post-apartheid era)*	Not raised as an influence	Not raised as an influence *(Minister calls on global UHC movement as support for NHI; various external organizations provided technical expertise)*
Critical contextual factors of influence	Inheritance of inequitable & inefficient health system; First democratic government in an initially difficult economic climate; Macro-economic policy favored growth over redistribution; Period of significant public administration and health system reform	The HIV/AIDS epidemic & HIV/AIDS policy denialism; Rising private sector health costs; Political stability followed by leadership challenge within the ANC; Macro-economic policy favored growth over redistribution; 2008 economic crisis	Growing public health system crisis; Leadership challenges within the ANC at start and end of period; Growing awareness of large-scale public sector corruption, based on patronage politics; Growing macro-economic challenges *(Fierce student protests led to government commitment to free higher education)*

TABLE 1. Summarizing Nearly 25 Years of Health Financing Policy Debate in South Africa (using available documents; italics identify points additional to the source documents)

politics appear to have played a significant role at any time. Yet the rise of private sector costs in the 2000s and the growing public system crisis in the 2010s might have provided opportunities to generate public support for broader financing reform.[11] In addition, there has been some recent contestation from the provincial government level around current NHI proposals, which seem to threaten their role and powers in the health system.[11] Finally, Table 1 highlights how broader contextual factors not only underpinned the contestation experienced over time—but also, at times, distracted from (e.g., HIV/AIDS policy debates, political tensions within the ANC, student protests), or provided opportunities for (e.g., leadership change within the ANC), moving financing policy change forwards.

USING THE POLITICAL ECONOMY FRAMEWORK TO SUPPORT FINANCING POLICY REFORM

Sparkes et al.[6] make clear that the application of this framework is intended to feed into the development of political strategies to support policy change, rather than primarily being a tool for retrospective analysis. Further reflection about South African experience highlights four issues to consider in terms of this practical application.

First, for the framework to be used as a strategy tool, a team or group within the central public bureaucracy must be mandated with developing political strategies to manage financing reform, and must have relevant expertise and experience. This role goes well beyond the technical and analytic work that is more usually the focus of health financing or policy analysis units within public bureaucracies.

In the early stages of financing reform in South Africa, for example, the national Directorate of Health Financing and Economics (established to conduct relevant analytic work) was simply too powerless to perform this broader role, and lacked experience and expertise. Whilst relationships with external health economists strengthened the Directorate's analytic capacity, these analysts did not bring sufficient political awareness to their work at this time.[8]

Twenty years later, Waterhouse et al.[11(p28)] reported that NHI is "poorly integrated in the Department, considered by some as an 'add-on', there are challenges with coordination, and differences in ideology and approach affect the cohesion of efforts." Although work towards NHI is now coordinated within the national Department of Health by a much more

senior civil servant than in the early years of financing reform, there are few other technical experts engaged in this work, challenges are experienced in coordinating work across multiple units and groups, and with the Treasury, and the use of external consultants limits the extent to which their work is integrated with other departmental activities.[11] In 2018, moreover, a new team, led from the Presidency, appeared to be taking charge of the reform process. However, it remains unclear whether purposeful, political management of the financing reform process is itself seen as part of the mandate and role, or is a skill set, of those working towards implementing NHI reforms.

The first step in applying a political economy lens to support financing reform is, then, to establish a central level strategy team that is mandated, and has the relevant expertise, to support the reform process. Bringing together officials from Health and Treasury/Finance may often be important, as in South Africa. More broadly, the expertise such a team needs includes the skills required to conduct stakeholder analyses and develop political strategies—as well as considerable experience of the political and bureaucratic context, formal communication expertise and personal, and ethical awareness.[12] Knowing your context is especially important in making the sorts of judgements that are required in stakeholder analysis and in developing relevant political strategies. Earlier work on health reform change teams offers additional insights on the role and expertise needs of such teams,[13] and such teams might be considered within the bureaucratic politics dimension of the framework.

Second, the team charged with supporting financing reform implementation simply must have strong relationships with high-level political leaders whilst, at the same time, these leaders must actively work with their strategy team.

Leadership politics is a central element of the framework.[6] Political leadership and leaders able to manage the internal politics of their party or government as well as interest groups and external actors, are a necessary resource for implementation. In addition, these leaders must trust their financing reform team. In early South African experience, distrust between the then Minister of Health and the financing technical team undermined policy development in that era.[8] Across periods, and quite different political contexts, the personalized nature of Ministerial leadership for health financing reform was another constraint to policy reform—limiting consideration of the wider evidence base and engagement with wider expertise, or leading to policy concessions to interest groups that seemingly contradicted the broad goals of NHI.[8,11] As politicians are ultimately not able to direct the overall process of implementation, they must—if truly committed to UHC goals—allow and support strategy teams to do the work required to move reforms from ideas to legislation and on to systemic change. Indeed, at a system level, the separation of political and administrative spheres of influence is widely recognized as a necessary facet of the governance arrangements needed to support well performing health systems.[14,15]

Third, the framework[6] suggests it is important to think carefully about beneficiary politics, but Table 1 suggests that the voice of beneficiaries has been quiet or non-existent in South African financing debates. Perhaps, as Waterhouse et al.[11(p52)] note, this is because "public knowledge and understanding of South Africa's NHI is limited," and NHI reform is certainly complex and multi-faceted. Yet, these authors also comment that public opinion data from 2012 suggest a base of popular support for NHI (which could be grown), even though most sources of public information are biased towards the private health sector and middle-class interests; whilst other analysts have suggested that communications targeting the middle classes around the notion of social solidarity could garner wider support.[11]

Overall, then, beneficiary silence in South Africa may well reflect a failure to engage the broader public around the values and goals of financing reform around the public value it can deliver. Since 2007, the Minister of Health has been a vocal NHI proponent,[11] but there has been little evidence of a wider and pro-active political communication strategy focused around clear messages or narratives, and aimed at generating wider understanding and support for NHI goals. Such support might, in turn, sustain policy change despite contestation among policy actors. Political leaders always have a legitimate role in setting out the driving vision for financing reform, but a broader, pro-active communication strategy is likely to need the support of a strategy team with relevant skills. Stakeholder analysis must be combined with communication expertise, for example; media engagement is essential. Alliances with civil society organizations may also support popular mobilization, but such networking demands its own skills as well as risk management. Whilst experience presented in the Sparkes et al. paper[6] might suggest that tweaking policy design may also be a relevant strategy in relation to beneficiary politics, this holds the risk of creating unexpected opposition in response to new design features, or of undermining the potential to achieve policy goals.[8,12]

Fourth, in seeking to support policy implementation—beyond policy formulation—the central level strategy team must take account of the multi-level nature of bureaucracies and health systems, as well as the discretionary power of

street level bureaucrats to resist or support change.[16,17] As Campos and Reich[18] note, significant reform, like financing reform, ultimately requires organizations and people to behave differently and so commonly disrupts the status quo and almost inevitably generates resistance. Such reform requires the management of actors all along the implementation chain, as well as the relationships between them, even as those relationships are themselves being tested by the reform. These contestations go beyond the issues of bureaucratic politics currently considered in the Sparkes et al. framework,[6] and yet often cause policy implementation blockages and are widely recognized as central to the efforts to improve quality of care and develop system resilience that must accompany UHC.[19]

In South Africa, for example, given the quasi-federal nature of the political and administrative system, the 2018 NHI Bill challenges the current health system powers and roles of provincial governments—and may require revisions to the 2003 National Health Act and even the 1996 Constitution. Provincial governments' resistance to these proposals may be partly offset by political alliances between the national Minister and provincial Ministers of Health from the ruling party (the ANC), although wider contestation within the ANC may underlie such resistance.

At the same time, the quite instructive approach to health policy implementation, including financing reform, commonly adopted by national level policy actors has itself generated challenges for new policies across the health system.[20] Only limited efforts were previously made by the national Minister and Department to engage provincial departments over NHI or listen to their concerns and ideas about implementation.[11] Further, the proposals suggest that the DHS will play a critical role in the envisaged NHI system, including in managing private sector provider contracting. Yet in most provinces the capacity of the DHS is currently so weak that it will need considerable development to be able to play this role.[11] There is no clarity about how this capacity development will occur and managing it from the national level makes little sense given the size and diversity of the country, and the NDOH's own capacity limits. Provincial governments might, then, be an important intermediary in developing the public health system envisaged in the NHI proposals—but wider political action would first be needed to address the egregious governance failures indicated by corruption scandals (state capture) in some provinces.[21]

Finally, the middle managers located at district, sub-district and facility level are all also critical players in implementing financing and other health reforms. They mediate and translate all policy and managerial imperatives received from higher level authorities for lower level managers and front line health providers, and through this role can either enable collective action towards policy goals or exacerbate workplace challenges and morale—with consequences for patient experience of health care and the broader public's understanding of the policies being implemented.[22,23] Capacity development for NHI requires then, developing distributed leadership across the health system alongside the organizational cultures that support the exercise of this leadership, and appropriate delegation of powers.[20,23,24]

These experiences indicate that in relation to bureaucratic politics it is important for the central strategy team to think beyond the early stages of policy implementation, to consider both how to manage implementation over time and how to strengthen the wider health system so that it routinely harnesses the collective action needed to sustain implementation.[25] This team cannot itself direct or manage the full chain of actors involved in the continuing processes of implementation. It can, however, engage with those who routinely do this management, seeking their advice and ideas about financing reform implementation. It can also establish the processes of learning-through-implementation that allow necessary policy re-development and innovation, and themselves help build system capacity.[8] Such learning could be supported by the action, monitoring and reflection cycles common to quality improvement processes,[19] for example, alongside other capacity strengthening efforts (see below). In South Africa, meanwhile, more direct engagement with provincial and district health managers about the opportunities for, and likely challenges of, implementing NHI-linked reforms is essential in the future; as well as purposeful piloting around focused reform issues accompanied by deliberate learning and evaluation strategies.

Wider experience[14,15] offers further, specific suggestions about how to strengthen system capacity to support policy implementation. Central strategy teams should plan system-wide leadership development, alongside structural changes to re-distribute power down the system. They should also consider how formal planning, budgeting, procurement and human resource management processes can be adapted to enable the multiple actors of the system to work towards agreed and shared goals. However, new forms of monitoring and tracking to support learning and strengthened mechanisms of public and peer accountability must be established from the bottom up, in response to experience and to changing system and context realities.[19,25] Guiding top-down and bottom-up strategies of system strengthening towards the goal of capacity development represent stewardship. Ultimately, this is a system characteristic that must be embedded into the governance arrangements and processes

of the health system and brought alive by leadership,[26] rather than a task of political management exercised exclusively by a central leadership or reform team.

CONCLUSION

South African experience illustrates that health financing reform must be recognized as a primarily political rather than technical process. Strategic planning for reform must, then, embrace political management—of the obvious government and interest groups, as well as the less obvious front-line implementers and indeed, the public at large, whom reform is intended to benefit but who are often overlooked. This special issue breathes new life into the importance of political economy analysis. Application of this analytical lens demands a dedicated and mandated multidisciplinary team located at national level, engaged with political leaders, but also able to support communication with the public and develop the health system's everyday capacity to manage the politics of implementation and sustain reform over time.

DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflicts of interest were disclosed.

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